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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Licensed Midwives
Certified Nurse Midwives
Birthing Centers
Managed Care Plans

From: Douglas Porter, Assistant Secretary
Assistance Administration (MAA)

Memorandum No: 04-40 MAA
Issued: June 23, 2004

For Information Call:
1-800-562-6188

Supersedes: 03-30 MAA
03-84 MAA

Subject: Planned Home Births and Births in Birthing Centers: Fee Schedule Changes and Maternity Policy Updates

Effective for dates of service on and after July 1, 2004, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2004 relative value units (RVUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The Year 2004 additions of Current Procedural Terminology (CPT™) codes;
- The additions to Healthcare Common Procedure Coding System (HCPCS) Level II codes; and
- Maternity policy updates.

Maximum Allowable Fees

MAA is updating the Planned Home Births and Births in Birthing Centers fee schedules with Year 2004 RVUs and clinical laboratory fees. The maximum allowable fees have been adjusted to reflect these changes. The 2004 Washington State Legislature **did not appropriate a vendor rate increase** for the 2005 state fiscal year.

Prenatal Assessment

Effective for dates of service on and after July 1, 2004, MAA will no longer reimburse providers for prenatal assessments. Assessment activities are considered part of the global maternity package. If a client is seen for reasons other than routine antepartum care, Certified Nurse Midwives (ARNPs) must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

Newborn Screening Fee Update

Retroactive to dates of service on and after June 1, 2004, the Washington State Board of Health has added three additional disorders to the mandatory newborn screening requirements. This change has increased the metabolic screening fee per infant to $60.90. The following tests are included in the mandatory dried blood screen:

- PKU;
- CAH;
- Congenital hypothyroidism;
- Hemoglobinopathies;
- Biotinidase deficiency;
- MSUD;
- MCAD;
- Homocystinuria; and,
- Galactosemisa.

Maternity Policy Updates

There have been significant updates made to MAA's maternity billing guidelines. Attached are replacement pages G.1 – G.4e and H.1 – H.6 to MAA's Planned Home Births Billing Instructions, dated July 2003. Attached are replacement pages D.1-D.4e and F.1-F.8 to MAA's Births in Birthing Centers Billing Instructions, dated July 2003.

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Billing

Billing – Specific to Planned Home Births

Effective for dates of service on and after July 1, 2004, MAA will no longer reimburse providers for prenatal assessments. If a client is seen for reasons other than routine antepartum care, eligible providers (ARNPs) must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

☞ **Exception:** Providers must bill E&M codes for antepartum care if only 1-3 antepartum visits are done, as discussed later in these billing instructions.

Global (Total) Obstetrical Care

Global OB care (CPT codes 59400) includes:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using one of the global OB procedure codes.

☞ **Note:** **Do not** bill MAA for maternity services until all care is completed.

Unbundling Obstetrical Care

In the situations described below, you may not be able to bill MAA for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as MAA may have paid another provider for some of the client's OB care, or you may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to your practice late in the pregnancy…

- If the client has had antepartum care elsewhere, you will not be able to bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care prior to the transfer bills for the services that he/she performed. Therefore, if you bill the global OB package, you would be billing for some antepartum care that another provider has claimed.

- OR -

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

  In this case, you may actually perform all of the components of the global OB package in a short time. MAA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

If your client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy…

Only those services you actually provide to the client may be billed to MAA.

If your client changes insurance during her pregnancy…

Often, a client will be fee-for-service at the beginning of her pregnancy, and then be enrolled in a MAA managed care plan for the remainder of her pregnancy. MAA is responsible for reimbursing only those services provided to the client while she is on fee-for-service. The managed care plan reimburses for services provided after the client is enrolled with the plan.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

Antepartum Care

Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Coding for Antepartum Care Only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

  Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

- If the client had a **total** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

☞ **Note:** **Do not** bill MAA until all antepartum services are complete.

Coding for Deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, you must bill MAA using the vaginal delivery only code (CPT code 59409).

If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill MAA using the vaginal delivery, including postpartum care code (CPT code 59410).

Coding for Postpartum Care Only

If it is necessary to unbundle the OB package and bill for postpartum care only, you must bill MAA using CPT code 59430 (postpartum care only).

If you provide all of the antepartum and postpartum care, but do not perform the delivery, bill MAA for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Increased Monitoring

When providing **increased monitoring** for the conditions listed on page E.1 – E.2 in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

If the client has one of the conditions listed on page E.1 –E.2, the provider is not automatically entitled to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.

Note: Licensed midwives are limited to billing for certain medical conditions (see page E.1 – E.2) that require additional monitoring under this program.

For example:

Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits, and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, attended the client during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care and attended the client during labor, but transferred the client to another provider (outside of your group practice) for delivery, you must unbundle the global OB package and bill separately for antepartum care and the time spent managing the client's labor. The client must be in active labor when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill MAA for the time spent attending the client's labor using the appropriate CPT E&M **codes ~~99211-99215 with modifier TH~~ (for labor attended in the office) ~~or~~ 99347-99350** (for labor attended at the client's home). In addition, MAA will reimburse providers for **up to three hours** of labor management using prolonged services CPT **codes 99354-99357 with modifier TH**. Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

☞ **Note**: The E&M code and the prolonged services code(s) **must** be billed on the same claim form.

Department of Health (DOH) Newborn Screening Tests

A midwife or physician may bill MAA for a newborn screening test for metabolic disorders (HCPCS code S3620) after paying DOH for the cost of the test. The newborn screening panel includes screens for:

- PKU;
- CAH;
- Congenital hypothyroidism;
- Hemoglobinopathies;
- Biotinidase deficiency;
- MSUD;
- MCAD;
- Homocystinuria; and,
- Galactosemisa.

Reimbursement includes two tests for two different dates of service, and is **allowed once per newborn.** Do not bill MAA for the newborn screening test if the baby is born in the hospital.

Immunizations

Immunization administration CPT codes 90471 and 90472 may be billed only when the materials are not received free of charge from DOH. For information on Immunizations, please refer to MAA's Physician-Related Services Billing Instructions or EPSDT Billing Instructions.

You may view these billings instructions online at **http://maa.dshs.wa.gov** (click on the "Provider Publications/Fee Schedules" link).

Home Birth Kit

When disposable items are used, bill MAA for a home birth kit using HCPCS code S8415. Reimbursement is **limited to one per client, per pregnancy.**

Medications

Certain medications can be billed separately and are listed on the fee schedule. Some of the medications listed in MAA's fee schedule are not billable by Licensed Midwives. By law, a licensed midwife may obtain and administer only certain medications. Drugs listed as "not billable by a licensed midwife" must be obtained at a pharmacy with a physician order. If you are unable to obtain a medication from a pharmacy and are using from your own supply, **see Section F - Authorization** for further information on billing**.**

☞ **Note**: Drugs must be billed using the procedure codes listed in the fee schedule and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review.

Newborn Assessment

To bill for a newborn assessment completed at the time of the home birth, providers must bill using CPT code 99432. Reimbursement is **limited to one per newborn.** Do not bill CPT code 99432 if the baby is born in a hospital.

Home Births Outcome Reports

The purpose of the Planned Home Births Outcome Report(s) is to provide the following data to MAA: prenatal history, transfer, and perinatal complications. The data is used to maintain a quality and outcomes monitoring process by analyzing data to evaluate the clinical practice of MAA's planned home birth providers.

You must submit a copy of the **Home Births Outcome Report(s)** and your claim form to the appropriate addresses as listed in the *Important Contacts* section (page iii). The one page short form can be completed if you are billing for antepartum care only.

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Fee Schedule

Due to its licensing agreement with the American Medical Associations, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

Use the following procedure codes when billing for Planned Home Birth services:

Routine Antepartum Care			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
☞ **Note:** CPT codes 59425, 59426, or E&M codes 99211-99215 TH with normal pregnancy diagnoses V22.0-V22.2 **may not** be billed in combination during the entire pregnancy. **Do not bill MAA for antepartum care until all antepartum services are complete.**			
59425		Antepartum care, 4-6 visits. **Limited to 1 unit per client, per pregnancy, per provider.**	$442.38 Typo fixed 7/22/04
59426		Antepartum care, 7 or more visits. **Limited to 1 unit per client, per pregnancy, per provider.**	776.72 Typo fixed 7/22/04
99211	TH	Office visits, antepartum care 1-3 visits, w/obstetrical service modifier. **99211 – 99215 limited to 3 units total, per pregnancy, per provider.** Must use modifier TH when billing.	14.25
99212	TH	Office/outpatient visit, est	25.25
99213	TH	Office/outpatient visit, est	35.25
99214	TH	Office/outpatient visit, est	55.00
99215	TH	Office/outpatient visit, est	79.75

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Additional Monitoring

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
☞ **Note:** Midwives who provide increase monitoring for the diagnoses listed on pages E.1 and E.2 and are seen in excess of the CPT guidelines for routine antepartum care may bill using the appropriate E&M code with the modifier TH.			
99211	TH	Office/outpatient visit, est	$14.25
99212	TH	Office/outpatient visit, est	25.25
99213	TH	Office/outpatient visit, est	35.25
99214	TH	Office/outpatient visit, est	55.00
99215	TH	Office/outpatient visit, est	79.75

Delivery (Intrapartum)

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
59400		Obstetrical care [prenatal, delivery, and postpartum care]	$1,899.78
59409		Obstetrical care [delivery only]	943.89
59410		Obstetrical care [delivery and postpartum only]	1,056.37

Postpartum

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
59430		Care after delivery [postpartum only]	$167.17

Labor Management

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
☞		**Note:** Bill only when the client labors at ~~the birthing center or at~~ home and is then transferred to a hospital, another provider delivers the baby, and a referral is made during active labor. The following diagnoses must be used 640–674.9; V22.0–V22.2; and V23–V23.9.	
☞		**Note:** Labor management may not be billed by the delivering physician. Prolonged services must be billed on the same claim form as E&M codes along with modifier TH and one of the diagnoses listed above must be on each detail line of the claim form.	
~~99211~~	~~TH~~	~~Office/outpatient visit, est (Use when client labors at birthing center)~~	~~$14.25~~
~~99212~~	~~TH~~	~~Office/outpatient visit, est~~	~~25.25~~
~~99213~~	~~TH~~	~~Office/outpatient visit, est~~	~~35.25~~
~~99214~~	~~TH~~	~~Office/outpatient visit, est~~	~~55.00~~
~~99215~~	~~TH~~	~~Office/outpatient visit, est~~	~~79.75~~
99347	TH	Home visit, est patient	26.98
99348	TH	Home visit, est patient	45.79
99349	TH	Home visit, est patient	70.96
99350	TH	Home visit, est patient	103.15
+ 99354	TH	Prolonged services, 1st hour. **Limited to 1 unit.**	58.72
+ 99355	TH	Prolonged services, each add'l 30 minutes. **Limited to 4 units.**	58.26

(+) = Add-on code

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Other			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
59025		Fetal non-stress test	$48.91
59025	TC	Fetal non-stress test	11.56
59025	26	Fetal non-stress test	37.35
36415		Drawing blood	2.45
84703		Chorionic gonadotropin assay	8.36
85013		Hematocrit	2.64
85014		Hematocrit	2.64
A4266		Diaphragm	45.0
A4261		Cervical cap for contraceptive use	47.0
57170		Fitting of diaphragm/cap	56.90
90782		Injection, sc/im	11.34
90371		Hep b ig, im **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	116.28 per each 1 ml
J2790		Rh immune globulin	89.76
J2540		Injection, penicillin G potassium, up to 600,000 units. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	0.26
S0077		Injection, clindamycin phosphate, 300 mg. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	Acquisition Cost
J0290		Injection, ampicillin, sodium, up to 500mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	1.48

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
J1364		Injection, erythromycin lactobionate, per 500 mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	$3.14
J7050		Infusion, normal saline solution, 250cc	2.22
S5011		5% dextrose in lactated ringer's, 1000 ml.	Acquisition Cost
J7120		Ringers lactate infusion, up to 1000cc	11.13
J2210		Injection methylergonovine maleate, up to 0.2mg	3.67
J3475		Injection, magnesium sulfate, per 500 mg	0.20
J2590		Injection, oxytocin	1.15
J0170		Injection adrenalin, epinephrine, up to 1ml ampule	2.10
J3430		Injection, phytonadione (Vitamin K) per 1 mg.	1.98
90708		Measles-rubella vaccine, sc	21.81
90471		Immunization admin	5.00
90472		Immunization admin, each add **[List separately in addition to code for primary procedure.]**	3.00
S3620		Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel. **[Department of Health newborn screening tests for metabolic disorders. Includes 2 tests on separate dates; one per newborn.]**	60.90

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
99401		Preventive counseling, indiv [approximately 15 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only]**	$25.39
99402		Preventive counseling, indiv [approximately 30 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only]**	42.62
99432		Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s). **Limited to one per newborn. Do not bill MAA if baby is born in a hospital.**	72.45
99440		Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	90.45
92950		Cardiopulmonary resuscitation (e.g., in cardiac arrest)	113.12
S8415		Supplies for home delivery of infant. **Limited to 1 per client, per pregnancy.**	45.00

Billing

Billing - Specific to Births in Birthing Centers

Effective for dates of service on and after July 1, 2004, MAA will no longer reimburse providers for prenatal assessments. If a client is seen for reasons other than routine antepartum care, eligible providers (ARNPs) must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

☞ **Exception:** Providers must bill E&M codes for antepartum care if only 1-3 antepartum visits are done, as discussed later in these billing instructions.

Global (Total) Obstetrical Care

Global OB care (CPT codes 59400) includes:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using one of the global OB procedure codes.

☞ **Note:** **Do not** bill MAA for maternity services until all care is completed.

Unbundling Obstetrical Care

In the situations described below, you may not be able to bill MAA for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as MAA may have paid another provider for some of the client's OB care, or you may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to your practice late in the pregnancy…

- If the client has had antepartum care elsewhere, you will not be able to bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, if you bill the global OB package, you would be billing for some antepartum care that another provider has claimed.

- OR -

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

  In this case, you may actually perform all of the components of the global OB package in a short time. MAA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

If your client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy…

Only those services you actually provided to these clients may be billed to MAA.

If your client changes insurance during her pregnancy…

Often, a client will be fee-for-service at the beginning of her pregnancy, and then be enrolled in a MAA managed care plan for the remainder of her pregnancy. MAA is responsible for reimbursing only those services provided to the client while she is on fee-for-service. The plan reimburses for services provided after the client is enrolled with the plan. However, each plan has their own policy on Birthing Centers, home births, and the use of midwifery services. You must check with each plan to determine their policy on these services.

When a client changes from one plan to another, <u>you must</u> bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

Antepartum Care

Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Coding for Antepartum Care Only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

  Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

- If the client had a **total** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

☞ **Note:** **Do not** bill MAA until all antepartum services are complete.

Coding for Deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, you must bill MAA using the vaginal delivery only code (CPT code 59409).

If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill MAA using the vaginal delivery, including postpartum care code (CPT code 59410).

Coding for Postpartum Care Only

If it is necessary to unbundle the OB package and bill for postpartum care only, you must bill MAA using CPT code 59430 (postpartum care only).

If you provide all of the antepartum and postpartum care, but do not perform the delivery, bill MAA for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Increased Monitoring

When providing **increased monitoring** for the conditions listed on page C.1 – C.2 in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

If the client has one of the conditions listed on page C.1 – C.2, the provider is not automatically entitled to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.

Note: Licensed midwives are limited to billing for certain medical conditions (see page C.1 – C.2) that require additional monitoring under this program.

For example:

Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits, and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, attended the client during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care and attended the client during labor, but transferred the client to another provider (outside of your group practice) for delivery, you must unbundle the global OB package and bill separately for antepartum care and the time spent managing the client's labor. The client must be in active labor when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill MAA for the time spent attending the client's labor at the birthing center using the appropriate CPT E&M **codes 99211-99215 with modifier TH**. In addition, MAA will reimburse providers for **up to three hours** of labor management using prolonged services CPT **codes 99354-99357 with modifier TH**. Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

☞ **Note**: The E&M code and the prolonged services code(s) **must** be billed on the same claim form.

Department of Health (DOH) Newborn Screening Tests

A midwife or physician may bill MAA for a newborn screening test for metabolic disorders (HCPCS code S3620) after paying DOH for the cost of the test. The newborn screening panel includes screens for:

- PKU;
- CAH;
- Congenital hypothyroidism;
- Hemoglobinopathies;
- Biotinidase deficiency;
- MSUD;
- MCAD;
- Homocystinuria; and,
- Galactosemisa.

Reimbursement includes two tests for two different dates of service, and is **allowed once per newborn.** Do not bill MAA for the newborn screening test if the baby is born in the hospital.

Immunizations

Immunization administration CPT codes 90471 and 90472 may be billed only when the materials are not received free of charge from DOH. For information on Immunizations, please refer to MAA's Physician-Related Services Billing Instructions or EPSDT Billing Instructions.

You may view these billings instructions online at **http://maa.dshs.wa.gov** (click on the "Provider Publications/Fee Schedules" link).

Medications

Certain medications can be billed separately and are listed on the fee schedule. Some of the medications listed in MAA's fee schedule are not billable by Licensed Midwives. By law, a licensed midwife may obtain and administer only certain medications. Drugs listed as "not billable by a licensed midwife" must be obtained at a pharmacy with a physician order. If you are unable to obtain a medication from a pharmacy and are using from your own supply, **see Section F - Authorization** for further information on billing**.**

☞ **Note**: Drugs must be billed using the procedure codes listed in the fee schedule and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review.

Newborn Assessment

To bill for a newborn assessment completed at the time of the birth in the birthing center, providers must bill using CPT code 99432. Reimbursement is **limited to one per newborn.** Do not bill CPT code 99432 if the baby is born in a hospital.

Billing - Specific to Birthing Centers (Facility Fees)

Facility Fee

When billing for the facility fee, use CPT code 59409 with modifier SU. Only a facility licensed as a childbirth center by DOH and approved by MAA is eligible for a facility fee. Bill this fee only when the baby is born in the facility. The facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication. The facility fee does not include other drugs, professional services, lab charges, ultrasound, other x-rays, blood draws, or injections.

Facility Transfer Fee

The facility may bill MAA for this fee when the mother is transferred in active labor to a hospital for delivery there. Use CPT code S4005 when billing for the facility transfer fee.

Procedure Code/ Modifier	Summary of Description	Limits
59409 SU	Delivery only code with use of provider's facility or equipment modifier.	Limited to one per client, per pregnancy.
S4005	Interim labor facility global (labor occurring but not resulting in delivery)	Limited to one per client, per pregnancy; may only be billed when client labors in the birthing center and then transfers to a hospital for delivery.

☞ **Note:** Payments for facility use are limited to only those providers who have been approved by MAA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only.

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Fee Schedule

Due to its licensing agreement with the American Medical Associations, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

Use the following procedure codes when billing for Birthing Center services:

Routine Antepartum Care

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
☞	**Note:**	CPT codes 59425, 59426, or E&M codes 99211-99215 with normal pregnancy diagnoses V22.0-V23.9 **may not** be billed in combination during the entire pregnancy. **Do not bill MAA for antepartum care until all antepartum services are complete.**	
59425		Antepartum care, 4-6 visits. **Limited to 1 unit per client, per pregnancy, per provider.**	$442.38
59426		Antepartum care, 7 or more visits. **Limited to 1 unit per client, per pregnancy, per provider.**	776.72
99211	TH	Office visits, antepartum care 1-3 visits, w/obstetrical service modifier. **99211 – 99215 limited to 3 units total, per pregnancy, per provider.** Must use modifier TH when billing.	14.25
99212	TH	Office/outpatient visit, est	22.25
99213	TH	Office/outpatient visit, est	35.25
99214	TH	Office/outpatient visit, est	55.00
99215	TH	Office/outpatient visit, est	79.75

Corrected online only since original posting

Additional Monitoring

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
☞ **Note:** Midwives who provide increased monitoring for the diagnoses listed on page C.1 and C.2 and are seen in excess of the CPT guidelines for routine antepartum care may bill using the appropriate E&M code with modifier TH.			
99211	TH	Office/outpatient visit, est	$14.25
99212	TH	Office/outpatient visit, est	25.25
99213	TH	Office/outpatient visit, est	35.25
99214	TH	Office/outpatient visit, est	55.00
99215	TH	Office/outpatient visit, est	79.75

Delivery (Intrapartum)

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
59400		Obstetrical care [prenatal, delivery, and postpartum care]	$1,899.78
59409		Obstetrical care [delivery only]	943.89
59410		Obstetrical care [delivery and postpartum only]	1,056.37

Postpartum

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
59430		Care after delivery [postpartum only]	$167.17

Labor Management

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
☞		**Note:** Bill only when the client labors at the birthing center and is then transferred to a hospital, another provider delivers the baby, and a referral is made during active labor. The following diagnoses must be used 640–674.9; V22.0–V22.2; and V23–V23.9.	
☞		**Note:** Labor management may not be billed by the delivering physician. Prolonged services must be billed on the same claim form as E&M codes along with modifier TH and one of the diagnoses listed above (all must be on each detail line of the claim form).	
99211	TH	Office/outpatient visit, est (Use when client labors at birthing center)	$14.25
99212	TH	Office/outpatient visit, est	25.25
99213	TH	Office/outpatient visit, est	35.25
99214	TH	Office/outpatient visit, est	55.00
99215	TH	Office/outpatient visit, est	79.75
+ 99354	TH	Prolonged services, 1st hour. **Limited to 1 unit.**	58.72
+ 99355	TH	Prolonged services, each add'l 30 minutes. **Limited to 4 units.**	58.26

(+) = Add-on code

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Other			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
59020		Fetal contract stress test	$37.41
59020	TC	Fetal contract stress test	13.83
59020	26	Fetal contract stress test	23.80
59025		Fetal non-stress test	48.91
59025	TC	Fetal non-stress test	11.56
59025	26	Fetal non-stress test	37.35
36415		Drawing blood	2.45
84703		Chorionic gonadotropin assay	8.36
85013		Hematocrit	2.64
85014		Hematocrit	2.64
A4266		Diaphragm	45.00
A4261		Cervical cap for contraceptive use	47.00
57170		Fitting of diaphragm/cap	56.90
90782		Injection, sc/im	11.34
90371		Hep b ig, im **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	116.28 per each 1 ml
J2790		Rh immune globulin	89.76
J2540		Injection, penicillin G potassium, up to 600,000 units. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	0.26
S0077		Injection, clindamycin phosphate, 300 mg. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	Acquisition Cost

Corrected online only since original posting

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
J0290		Injection, ampicillin, sodium, up to 500mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	$1.48
J1364		Injection, erythromycin lactobionate, per 500 mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	3.14
J7050		Infusion, normal saline solution, 250cc	2.22
S5011		5% dextrose in lactated ringer's, 1000 ml.	Acquisition Cost
J7120		Ringers lactate infusion, up to 1000cc	11.13
J2210		Injection methylergonovine maleate, up to 0.2mg	3.67
J3475		Injection, magnesium sulfate, per 500 mg	.20
J2590		Injection, oxytocin	1.15
J0170		Injection adrenalin, epinephrine, up to 1ml ampule	2.10
J3430		Injection, phytonadione (Vitamin K) per 1 mg.	1.98
90708		Measles-rubella vaccine, sc	21.81
90471		Immunization admin	5.00
90472		Immunization admin, each add **[List separately in addition to code for primary procedure.]**	3.00

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
S3620		Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel. **[Department of Health newborn screening tests for metabolic disorders. Includes 2 tests on separate dates; one per newborn.]**	$60.90
99401		Preventive counseling, indiv [approximately 15 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only]**	25.39
99402		Preventive counseling, indiv [approximately 30 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only]**	42.62
99432		Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s). **Limited to one per newborn. Do not bill MAA if baby is born in a hospital.**	55.88
99440		Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	90.45
92950		Cardiopulmonary resuscitation (e.g., in cardiac arrest)	113.12

Fee Schedule for Facility Fee Payment

MAA reimburses for a facility fee for only Birthing Centers licensed by the Department of Health that have a Core Provider Agreement with MAA.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
59409	SU	Delivery only code with use of provider's facility or equipment modifier. **Limited to one unit per client, per pregnancy.** Facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication.	$733.16
S4005		Interim labor facility global (labor occurring but not resulting in delivery). **Limited to one per client, per pregnancy.** May only be billed when client labors in the birthing center and then transfers to a hospital for delivery.	366.68

☞ **Note:** Payments for facility use are limited to only those providers who have been approved by MAA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only.

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